**TESTIMONY SUBMITTED REGARDING CONNECTICUT SENATE BILL 654**

**PUBLIC HEALTH COMMITTEE**

**Submitted by:**

**Andrew Friedell**
**Director, Government Affairs**
**Medco Health Solutions, Inc.**

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Madame Chairmen, and members of the Committee, my name is Andrew Friedell and I am a Director of Government Affairs for Medco Health Solutions, Inc., which is a pharmacy benefits management company, or "PBM." I would like to thank you for this opportunity to testify today regarding our concerns with Senate Bill 654. We believe that the underlying issues raised by this bill can best be addressed by the doctor, patient and pharmacist -- not by the legislature. If enacted, we believe that this bill will result in added costs and make it harder for Connecticut patients to receive affordable prescription drug coverage.

Medco is a leading provider of comprehensive, high-quality, affordable prescription drug care in the United States. We work with patients, pharmacists, physicians and health plan sponsors to improve the quality of pharmaceutical care provided to patients, while helping to control the growth in drug costs. We work under contract with health plan clients throughout the country that are providing prescription drug benefits for their members and employees, totaling more than 60 million covered lives. Our clients include very sophisticated health care purchasers, including: Fortune 500 corporations and smaller employers, local, state and federal

employee and retiree groups, Blue Cross/Blue Shield plans, unions, and insurance carriers and managed care plans.

We have serious concerns about Senate Bill 654 because it seeks to carve one class of drugs out of the state's generic substitution rules without any scientific evidence supporting such protections. This will drive up costs for patients and payors by making it harder for the patient to obtain a lower cost generic medication and by opening the door to additional legislation in the future seeking similar exemptions for other classes of medication.

The U.S. Food and Drug Administration, charged with approving new drug applications and applications for generic equivalent products, weighed in on this issue and made the following statement with regard to similar legislation under consideration in the state of Iowa:

> *FDA is aware that certain individuals and groups have expressed particular concern about the switch of anti-epileptic drug products. To date, we have no scientific evidence that demonstrates a particular problem with this group of products. Further, there are frequently circumstances other than the switch that may cause untoward responses. We continue to follow-up such reports and interact with those concerned.*

Furthermore, the FDA also noted that when a generic product is deemed to be therapeutically equivalent to the innovator product, there is no need for the provider to "approach any one therapeutic class of drug products differently from any other class…"[1]

In addition, the American Medical Association has also looked into this specific issue and determined in a letter dated August 30, 2007 that "After reviewing the scientific evidence, the CSAPH (Counsel on Science and Public Health of the AMA's House of Delegates, 2007)

[1] Letter from Gary Buehler, R.Ph., Director of the FDA Office of Generic Drugs, to Ms. Nicole Schultz of the Iowa Pharmacy Association, dated January 11, 2008.

concluded that a separate, more stringent generic substitution process for NTI (narrow therapeutic index) drugs was unnecessary."[2]

Given that both the FDA and AMA have weighed in effectively opposing special rules for this class of medications and given that there is no scientific evidence indicating that such special treatment is warranted, we urge the committee to leave this as a matter best addressed in discussions between the doctor, patient and pharmacist. Clearly, it is critical that physicians educate their patients about these matters and that pharmacists always inform patients when changes are made to their drug therapy.

Prescribers already have the ability to indicate if and when a drug can be substituted and when it should not. They have the right to indicate "dispense as written" on the prescription; *they do not need additional legislation to underscore that authority*. Therefore any risks associated with therapy changes in these medications are easily addressable under current law. In limiting drug substitution, S.B.654 creates new barriers between patients and safe and effective generic alternatives.

In addition, if the legislature decides to step in and limit generic substitution for this particular class of medications, it will no doubt open the door to addition legislation in the future seeking a similar exemption for other classes of medication. In fact, we understand that supporters of this measure have already highlighted the fact that a similar carve-out has already been enacted in Connecticut for the psychotropic drugs. There are numerous interest groups with strong opinions about a variety of disease states and drug categories. As a result, we fear that the passage of this legislation would be viewed by some as a "green light" to promote additional carve-out legislation that would further drive up the cost of prescription drug care.

[2] Letter from Michael D. Maves, MD, MBA, Executive Vice President and CEO of the American Medical Association, to Mark Merritt, President and CEO of the Pharmaceutical Care Management Association, dated August 30, 2007.

The potential long term cost implications of this legislation are particularly relevant when considering the anticonvulsant class of medications, due to the fact that several significant branded drugs in this category face patent expirations over the next few years. If the pathway to safe generic alternatives is obstructed, patients and payors will end up significantly overpaying for prescription drug care. For example, when the branded drug Zoloft lost patent protection in August of 2006, Medco's mail service pharmacies were able to convert 93% of these prescriptions to lower cost generic alternatives *within the first week following the patent expiration*. These generic products offer both immediate *and* long terms savings to patients and payors. In fact, FDA research on competition and generic drug prices found that generic drugs can be 80% less expensive than the brand name equivalent in drug categories that attract multiple generic competitors.[3] Furthermore, the difference in price inflation between brand and generic products can also generate long term savings as well. For example, in 2006 the average price inflation for generic drugs across Medco's book of business was 0.2% while the average price inflation for branded medications was 6.9%. This demonstrates that the higher cost of a branded drug is further compounded over time relative to generics -- thus exacerbating the long term problem for those purchasing the medications.[4]

Without any scientific evidence to justify these new rules, this legislation could result in significant and unnecessary increases in health care costs. In a time of rapidly escalating drug costs, we should be focused on encouraging the use of safe and effective cost control techniques, such as generic drugs, rather than discouraging them.

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[3] U.S. Food and Drug Administration, Center for Drug Evaluation and Research: "Generic Competition and Drug Prices." Available at: http://www.fda.gov/cder/ogd/generic_competition.htm (last accessed on 3/11/2008).
[4] Medco Drug Trend Report, 2007. Available at http://medco.mediaroom.com/file.php/129/2007+DRUG+TREND+REPORT.pdf (last accessed on 3/11/2008).

In summary, S.B. 654 aims to mediate issues which should simply be addressed through the communications that the prescriber and pharmacist have with the patient. No additional legislation is needed at this time. Thank you for your consideration of our views. I would be happy to answer any questions that members of the Committee might have.